MICHIGAN PERINATAL REGIONALIZATION

Work Group 5: NICU Transition and Follow-up

Work Group 5

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NICU Transition to Home and Follow-up Program

- Being a Level 3 Nursery (NICU) requires that there is a transition to home program and follow-up clinic.
- Formal assessment of the program initially and then every 2 years
- This will be assessent determined and carried out by a NICU transition to home and follow-up advisory team.

Home Visit

- All infants discharged from the NICU
- Ideally performed by a nurse who is skilled in the assessment of high risk infants
- 2 visits
  - One pre-discharge: to assess preparedness of family to bring their infant home
  - One post-discharge: within 1-2 weeks after discharge to assess how the infant is doing and how the family is adjusting to having their infant home

Home Visit

- Using a standardized assessment tool
- Nurses to do the home assessment through already existing programs. This is still being discussed through another subgroup
- Data will be collected and kept in a centralized database

NICU Follow-up Clinic

- Infants who meet criteria as outlined in the guideline will be referred to a follow-up clinic
- All NICU's to have a clinic or an arrangement with another NICU that has a clinic
- Satellite clinics needed to capture infants who live a distance from the regional center
- Team of clinicians as described in the guideline could be put together from hospital staff, Early On staff or staff from the health department

NICU Follow-up Clinic

- Standardized assessments tools will be used for the evaluation. These will be determined by an advisory group to the MDCH
- Data will be captured in a central data bank
- Negotiations with the insurance companies to pay for neurodevelopmental testing at the clinic visits

NICU Coordinator

- A nurse clinical coordinator will be necessary to link infants and families for home visits, follow-up and to do an assessment of the infants neurobehavioral status prior to discharge
- Meet with families to discuss the importance of the home visit and the follow-up clinic visits.
- Facilitate scheduling of the follow-up clinic visit
- Share neurobehavioral findings with the family and with early intervention

Annual Meeting

- Sponsored by MDCH
- Share outcomes
- Discuss the process and if it needs to be changed
- Discuss goals